Chronic Obstructive Pulmonary Disease Program

The chronic obstructive pulmonary disease program (COPD) is designed to modify risk factors associated with COPD as well as slow the progression of the disease. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Members with COPD require long-term, continual health care to maintain functional status and to help eliminate disease exacerbations. Program goals include:

- Slowing the progression or stabilization of symptoms of COPD
- Optimization of functional capacity
- Improvement in quality of life
- Reduction in frequency of hospitalization
- Facilitation and enhancement of the patient/doctor relationship

Member identification is conducted by ICD-10 analysis of ambulatory and inpatient claims and inpatient DRG 88. Diagnostic codes include: J41.xx, J42.xx, J43.xx, and J44.xx. Other methods of member identification include health risk screening and direct referral by the primary care physician or pulmonologist. Member stratification is based on severity of illness and frequency of hospitalization with exacerbations.

The COPD program relies on population-based measures of hospitalization utilization and emergency services utilization. The same measures are also used at the individual member level for those stratified as high-risk and who participate in The Health Plan’s telephonic COPD management program. Primary attention is given to the evaluation of appropriate medication use, education, and counseling about daily self-management and recognition of early COPD exacerbations.

Population-based chronic disease navigation strategies include targeted educational mailings throughout the year. High-risk members receive telephonic chronic disease navigation intervention from a COPD nurse navigator specialist who provides individualized interventions that include the evaluation of appropriate medication use, education, and counseling about daily self-management and recognition of early signs and symptoms of COPD exacerbations requiring intervention. Enrolled members receive home scales, if needed, smoking cessation interventions, if indicated, referrals for nutritional education, referrals for home oxygen/respiratory therapy, when indicated, pulmonary rehabilitation, and immunizations. Consideration of other health conditions, such as diabetes and chronic heart failure are included in the management program.
Initial management of acute exacerbations include identification of precipitating factors (e.g. infection, volume overload, pulmonary thromboembolism, environmental changes, or overuse of sedating medication) and tailoring drug therapy according to:

- The degree of reversible bronchospasm
- Prior therapy at a stable baseline
- Recent pharmacotherapy and prior medication toxicity
- Presence of contraindications to specific medications
- Specific therapies indicated by the precipitating cause of the exacerbation

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the member’s condition and information is gathered about health status, treatment plan and adherence, functional status, and quality of life. Ongoing monitoring by the COPD manager ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the nurse navigator is determined by the member’s severity of symptoms. This may result in daily contact in times of high-risk or concern as well as consultations with the physician. When home care is needed, the nurse navigator will work with the physician and home care agency to coordinate the necessary care and services.

A major component of the COPD program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and recognition of symptoms are included in the teaching process. These warning signs are reviewed each assessment call along with a review of medications and medication compliance. Education also includes the appropriateness of exercise, diet, self-management skills, the proper use of metered dose inhalers, and when indicated, smoking cessation interventions.

A successful COPD program is dependent on the coordination of health care services. The role of the physician is vital and this program is intended to compliment the medical care the member is receiving from his/her physician. The goal of the management program is to foster a collegial relationship between the physician and the complex case navigator in order to coordinate the necessary and appropriate care for the member. Evidence-based guidelines are available and recommended for use by the physician to medically manage their patients with COPD.